

ATTACHMENT 10

Sample Prior Authorization Request Form (PA/RF) for ambulance services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) completion instructions.

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|--|---|--|---|---|------------------------------------|--------------|
| FOR MEDICAID USE — ICN | | AT | Prior Authorization Number 1234567 | | | |
| SECTION I — PROVIDER INFORMATION | | | | | | |
| 1. Name and Address — Billing Provider (Street, City, State, Zip Code) I.M. Provider 10 W. Williams Anytown, WI 55555 | | 2. Telephone Number — Billing Provider (555) 123-4567 | 3. Processing Type 999 | | | |
| | | 4. Billing Provider's Medicaid Provider Number 87654321 | | | | |
| SECTION II — RECIPIENT INFORMATION | | | | | | |
| 5. Recipient Medicaid ID Number 1234567890 | 6. Date of Birth — Recipient (MM/DD/YY) 01/31/37 | | 7. Address — Recipient (Street, City, State, Zip Code) 609 Willow Anytown, WI 55555 | | | |
| 8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A. | | 9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F | | | | |
| SECTION III — DIAGNOSIS / TREATMENT INFORMATION | | | | | | |
| 10. Diagnosis — Primary Code and Description V82.9 Unspecified condition | | 11. Start Date — SOI | 12. First Date of Treatment — SOI | | | |
| 13. Diagnosis — Secondary Code and Description | | 14. Requested Start Date | | | | |
| 15. Performing Provider Number | 16. Procedure Code | 17. Modifiers 1 2 3 4 | 18. POS | 19. Description of Service | 20. QR | 21. Charge |
| | A0431 | | 21 | Ambulance service, conventional air services, transport, one way (rotary wing) | 1.0 | XX.XX |
| | A0436 | | 21 | Rotary wing air mileage, per statute mile | 60.0 | XX.XX |
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| An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO. | | | | | 22. Total Charges | XX.XX |
| 23. SIGNATURE — Requesting Provider I.M. Requesting | | | | | 24. Date Signed 02/05/04 | |
| FOR MEDICAID USE | | Procedure(s) Authorized: | | Quantity Authorized: | | |
| <input type="checkbox"/> Approved Grant Date Expiration Date | | | | | | |
| <input type="checkbox"/> Modified — Reason: | | | | | | |
| <input type="checkbox"/> Denied — Reason: | | | | | | |
| <input type="checkbox"/> Returned — Reason: | | | | | | |
| SIGNATURE — Consultant / Analyst | | | | Date Signed | | |